STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 00 B. WING	07/29/2011

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WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DRIVE BEDFORD, IN47421

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F0000	This visit was for the Investigation of Complaints IN00093639 and IN00094264. This visit resulted in a partially extended survey - immediate jeopardy. Complaint IN00093639-Substantiated. Federal/State deficiencies related to the allegations were cited at F-323, F-309, and F-490. Complaint IN00094264- Substantiated. Federal/State deficiencies related to the allegations were cited at F-323, F-309, and F-490. Survey date: 07/28/11 Extended survey date: 07/29/11 Facility number: 000060 Provider number: 155135 AIM number: 100266600 Survey Team: Sharon Whiteman, RN TC Marla Potts, RN (07/28/11) Melinda Lewis, RN Census Bed Type: SNF/NF: 76 Total: 76	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census Payor Type: Medicare: 16 Medicaid: 58 Other: 02 Total: 76 Sample: 03 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 2, 2011 by Bev Faulkner, RN			
F0309 SS=J	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents reviewed for facility bus transfers received timely assessment and care after the resident had fallen forward out of her wheelchair and lay face down on the floor of the van for approximately 1 and 1/2 hours resulting in the resident sustaining several bruises and abrasions. (Resident A)	F0309	What corrective action was taken for those residents found to have been affected by the deficient practice? 1-The employee who drove the van with Resident A was suspended on 7/12/11 pending investigation. The investigation was completed on 7/13/11, and the bus driver involved in the incident was terminated. 2- A care plan was developed on 7/12/11 for Resident A addressing resident's	07/30/2011

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	The Immediate Jeopardy began on 7/12/11 when Resident A was transported in the facility wheelchair van without a seat belt being in place. The driver of the van had to slam on his brakes when someone pulled in front of the van causing the resident to be propelled out of her wheelchair. The Resident laid on the van floor without medical assistance for approximately an hour and a half while the facility drove from Bedford to Indianapolis to assess her. The Administrator, RN Corporate Consultant and Director of Nursing were notified of the Immediate Jeopardy at 3:10 P.M. on 7/28/11. The immediate jeopardy was removed on 07/29/11 at 2:00 p.m., but noncompliance remained at the lowered scope and severity of isolated, at no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings Include: During interview of Resident A on 07/28/11 at 10:30 a.m., she indicated she had a "bad accident two weeks ago." Resident #A indicated she had gone out for a doctor's appointment in Indianapolis. Resident A indicated the driver had secured her wheel chair with straps, but		refusal to wear seat belt. The approach was added that the facility would no longer transport resident due to her non-compliance. Alternative transportation will be arranged as needed. 3-A system is now in place for van transportation and for the timely and proper assessment when an incident occurs. How other Residents having the potential to be affected by the same deficient practice were identified? On 7/28/11, each interviewable Resident in the facility was questioned about seat belt compliance while riding in the facility van. All residents interviewed answered they would not try to remove the seat belt while riding in the van. As such, no other Residents were identified with the potential of being affected. What measures were put into place or what systemic changes were made to ensure that the deficient practice does not recur? 1-On 7/12/11, a plan was instituted to have the approved van drivers be instructed, before any other transports took place, on the proper use of the seat belts. Completed on 7/13/11, instruction was provided to those drivers including placing those drivers in wheelchairs and having each of those drivers seat belting each other in. They were also instructed on what to do when a resident refuses to use a seat belt as well as what action to take	

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	she had refused to wear the seat belt due to she was too heavy and didn't like the way the seat belt "squeezed" her. Resident #A indicated upon arriving at the hospital she was told the appointment had been canceled. Resident A indicated she left the hospital with the driver and continued to not wear her seat belt. Resident A indicated they were on the interstate and a car swerved in front of them and the driver had to slam on his brakes and she fell forward "almost to the front of the bus." Resident A indicated the driver pulled over to the side of the road and attempted to get her up off the floor but was unable to because she was too heavy. Resident A indicated she told the driver she was o.k. and the driver called the facility to report what had happened. Resident A indicated the bus driver told her that he was instructed by the facility to leave the resident on the floor until the facility arrived to help her. Resident A indicated it was very uncomfortable on the floor and she couldn't believe she had to lay on the floor until the facility arrived. The resident indicated she was on the floor 2 hours before the Administrator and LPN #1 arrived to assist her up. Resident A indicated the Administrator and the driver turned her over and sat her up and LPN #1 assessed her. Resident #A raised her shirt at this time and seven bright red ridges,		when a fall or accident occurs (to call 911) immediately, whether or not the Resident believes they were injured. Assessment of learning was return demonstration. The instruction that was provided to all current drivers will also be provided to any new drivers assigned the responsibility of transporting Residents. New driver instruction begins with a Job Specific Orientation which includes wheelchair and seatbelt safety, as well as calling 911 in case of an emergency, such as if a fall or incident occurs.How the corrective action will be monitored to ensure the deficient practice will not recur? 1-Return demonstration, which includes how to properly apply seat belts and calling 911 if an incident occurs, will be completed three times weekly on anyone who drives the bus for the next thirty days; weekly, for three months; and monthly for at least three months. 2-Results of these return demonstrations will be delivered to the Continuous Quality Improvement (CQI) Committee for ongoing Quality Assurance review and appropriate follow-up as needed. Date changes completed – 7/29/2011	

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approximately 4 centimeters in length and 0.5 centimeters in width were observed across the resident's abdomen. Resident A indicated the ridges were due to laying on the bus floor.

Interview of LPN #1 on 07/28/11 at 11:15 a.m., indicated it took about 1 hour to get from the facility to Greenwood. LPN #1 indicated the Administrator had called a sister facility near the area of the facility bus and were told that staff from the sister facility would leave immediately to assist the resident. LPN #1 indicated she called the driver and told him the sister facility was on their way. LPN #1 indicated the driver had given an incorrect location and the sister facility was on the west side and the facility bus was on the east side. LPN #1 indicated the driver had followed Resident #A's instructions to get off of the interstate and had moved the bus with the resident laying on the floor. LPN #1 indicated when she and the Administrator found out that the facility bus was at a different location they called the sister facility and instructed them not to come due to the Administrator and LPN#1 were on their way and were closer to the location of the bus than the sister facility. LPN #1 indicated she assessed the resident and she was moving all extremities. LPN #1 indicated Resident #A was face down on the mat when they

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	arrived and was the exact same width as the aisle. LPN #1 indicated the resident denied any pain. LPN #1 indicated she and the Administrator slid a gait belt under the resident and after 3 attempts were able to move the resident to the back of the aisle where they could sit her up. LPN #1 indicated upon assessment of the resident, the resident was found to have red ridges across her abdomen, red blotches on her knees, and a bleeding elbow. LPN #1 indicated Resident A was able to tell her her name and where she lived and Resident A denied pain except a sore ankle. Interview of the Administrator on 07/28/11 at 11:40 a.m., indicated it didn't occur to him to call EMT's [Emergency Medical Technicians] due to the resident saying she wasn't hurt. The Administrator indicated he had called the sister facility and they said they would go to assist the resident. The Administrator indicated he then called the van driver to confirm the location and the van driver told him he had moved the van and had driven about 8 miles farther. The Administrator indicated he then realized he was closer to the van than the sister facility so he called the sister facility and told them not to come. The Administrator indicated the resident didn't request EMT's.			

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	Interview of the DON [Director of Nursing] on 07/28/11 at 2:15 p.m., indicated when the van driver called the facility to report what happened, her first thought was to call 911 due to EMT's would arrive sooner. The DON indicated the Administrator said he had talked to the resident and she was o.k. and a sister facility was going to the van location to help the resident. Interview of the Nurse Practitioner on 07/28/11 at 2:30 p.m., indicated Resident A had requested an increase in her Xanax [anti-anxiety medication] on 07/14/11 due to the resident having trouble sleeping. The Nurse Practitioner indicated that on 07/19/11 the resident complained of pain under her left breast. The Nurse Practitioner indicated the ridges on the resident's abdomen had opened and the dressing was sticking. The Nurse Practitioner indicated she palpated the resident's abdomen and the resident didn't complain of pain. Review of Resident A's clinical record on 07/28/11 at 12:55 p.m., indicated the following: Resident A had diagnoses which included, but were not limited to, CVA [stroke] and obesity.			

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	A Resident Progress Note, dated 07/12/11 at 6:45 a.m., indicated, "Resident [A] LOA to Dr...[name of doctor] in Indy via facility provided transportation." A Resident Progress Note, dated 07/12/11 at 11:00 a.m., indicated Resident A's vital signs were taken at that time and were as follows: Temperature - 97.3, heart rate - 80, respirations - 20, and blood pressure - 130/60. A Resident Progress Note, dated 07/12/11 at 1:00 p.m., indicated, "Arrived at van @ 11:00 a.m. resident lying face down in the floor/aisle of the van. Res [Resident A] denied any pain at this time. Res A&O [alert and oriented] to place, name, and staff present. Assessed face/neck, feet/ankles, and both arms for mobility. Denies any pain during the assessment. Gait belt was placed under the resident by ED [Executive Director] and LPN #1 & was hooked on her [Resident A] back side. ED lifted res slightly up while LPN #1 moved res towards the back of the bus from the aisle. 3 attempts and successful. ED and LPN #1, and (driver of van) lifted res with gait belt and each leg to reposition res in a sitting position. Head to toe assessment done per this nurse. All vital signs WNL. Right elbow bleeding from a previous injury. Pressure applied. Bruising on both knees, sheering on her			

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	belly. Purpura [areas of discoloration] on left forearm. Small abrasion on left elbow. Secured resident in wheelchair with should [shoulder] strap and lap belt and 4 point wheel belts. ED drove van and resident back to facility. This nurse notified DNS and DNS reported to [resident's physician], NP [Nurse Practitioner] at 12:30 p.m. regarding this incident." A Resident Progress Note, dated 07/12/11 at 1:15 p.m., indicated, "Resident returned from MD [Medical Doctor] appointment...." An X-ray, dated 07/12/11, indicated Resident A had "soft tissue swelling" of her right ankle. A Resident Progress Note, dated 07/13/11 at 1:46 p.m., indicated, "Resident up with assistance this shift. Resident received PRN [as needed] pain medication once this shift for general all over discomfort with effect. Resident was screen [screened] by therapy this shift and therapy is going to pick Resident up on caseload. Resident is propelling self in wheel chair to meals. Bruising continues to inferior left breast, purple in color. Slight discoloration also noted to left knee. Abrasions to abdomen have no signs or symptoms of infection. vital [sic]			

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	signs within normal limits, neuro checks WNL [within normal limits]. Call light in reach." A Resident Progress Note, dated 07/13/11 at 3:30 p.m., indicated, "IDT [Interdisciplinary Team] met to review residents fall on 7/12/2011 at 9:20 a.m. Resident fell out of chair while being transported to MD via facility van. Resident has several bruises and abrasions. Resident stated when the van stopped she fell out of her chair on to the van floor. When this nurse asked if she was belted in, resident stated, 'I wont [sic] wear a seat belt and if they put it on I [sic] just unhook it and hold it after they start to drive.' Neuro checks were started at the scene with nurse doing a head to toe assessment. MD/NP [Medical Doctor/Nurse Practitioner] and family notified. X ray to right foot and ankle done with no evidence of fracture. PT [Physical Therapy] OT [Occupational Therapy] to screen." A Resident Progress Note, dated 07/13/11 at 4:48 a.m., indicated, "Resident continues on F/U [follow-up] fall. Resident requested pain meds [medications] at 2:30 a.m. d/t [due to] hurting all over. Bruising noted to body in numerous places. Resing [Resting] quietly abed at this time."			

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A Resident Progress Note, dated 07/13/11 at 5:15 p.m., indicated, "[Name of Resident A's physician] here to see res [Resident A]. Rec'd [Received] w.o. [written order]."

A Resident Progress Note, dated 07/13/11 at 10:14 p.m., indicated, "Resident cont [continues] on f/u [follow-up] for fall. Resident has had some complaint of pain this shift. Complaint of genral [sic] pain all over. Pain medication given. Resident stated it did help...."

An X-ray, dated 07/20/11, indicated Resident A had no rib fractures.

An investigation form completed by the Director of Nursing, dated 7/12/11, indicated "...7/12/11 at 9:20 AM [sic] during morning meeting E.D. [Executive Director] received call from van driver (bus driver name). ED came to this nurse during meeting and told this nurse he and LPN #1 was going to assist van driver. ED stated van stopped and resident fell out of chair onto floor. After morning meeting at 10:10 AM [sic] this nurse called ED who was in route to van stating ambulance should be called in case of injury. ED had called sister facility in Indianapolis whom was close and DNS [Director of Nursing Services] with her

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	staff was going to assess resident and assist if ambulance needed to be called. ED explained he had talked with van driver and resident whom stated she was fine. 7/12/2011 LPN (name) stated she did head to toe assessment and initiated neuro checks when she arrived at van location, on resident. ED drove van back to facility. 7/13/2011 This nurse did head to toe assessment and measured each bruise and abrasion.... 7/12/2011 xray of R [right] foot and ankle. No fracture or dislocation. 7/20/2011 Xray ribs no fracture, NP [Nurse Practitioner] saw and examined resident on 7/15/2011 and 7/19/2011." Documentation titled "Timeline for [Resident A]" incident was provided by the Administrator on 07/29/11 at 11:10 a.m. The documentation was dated July 12, 2011. The Documentation indicated the following: "9:20 a.m. - Received call from bus driver that [name of resident] had fallen from her wheelchair and was on the floor of the van in indpls [Indianapolis]. Spoke with driver and [name of resident] on that call and determined that [name of resident] was not feeling any pain and in her words was alright. Told the driver that we would be coming to help and he told us their location.			

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	9:30 a.m. - ED [Executive Director] and Nurse set out to help. ED needed to get to the site since it sounded like the driver had been careless allowing the resident to fall and thus, the driver should not drive the bus or the resident any further. 10:17 a.m. - The drive was going to be about an hour and a half, so in route, we contacted our ASC building [sister facility] just west of Indpls. I asked if they could assist by going to the location of our bus, checking out the resident and waiting for us to arrive to the location. They said, yes. 10:25 a.m. - Spoke with our bus driver and told him that we had called another center. The other center would be coming to his location to assist. Asked the driver to confirm his location. He informed us that he had driven to another location that 'has less traffic.' His new location was now closer to us and further from the [name of sister facility] team that was in route to help. I told the driver to not drive any place and to stay at that location until our arrival. 10:30 a.m. - I called the [name of the sister facility] DNS [Director of Nursing Services] and told her that we were now closer than they were. They were in route to assist us. I thank [sic] them for their			

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	effort. 11:00 a.m. - We arrived at the location. Nurse performed initial assessment. We spoke with [name of resident] who said she was alright. We positioned [name of resident] better to get her into a sitting position. Nurse continued the assessment. We stood [name of resident] and placed her into her wheelchair. Nurse completed the assessment. 1:30 p.m. - Arrived back to [name of facility]. ED had driven the van back after confirming that driver had not properly seat-belted the resident allowing her to fall. Resident was wheeled into the center and then she wheeled herself into the main dining room and began setting the room up for the afternoon Bingo game." Documentation titled "RE: Incident with Van Driver and Resident on 7/12/11" was provided by the Administrator on 07/29/11 at 1:30 p.m. The documentation was dated, 07/28/11. The documentation listed interventions the facility implemented to correct the immediate jeopardy. The facility immediately inserviced van drivers that any resident being transported were to be properly seat belted and drivers were instructed on what to do when a resident refused to wear a			

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	seat belt. Resident A was care planned addressing her refusal to wear a seat belt and the driver involved in the incident was terminated. In the event of a fall/accident while en route during a transport, and a resident is not accompanied by nurse to provide immediate assessment, 911 will be called for immediate assessment for the resident and the DON and Administrator will immediately be contacted. The immediate jeopardy that began on 07/12/11 was removed on 07/29/11 when the facility inserviced all drivers on steps to take when a resident refused to use a seat belt and on steps to take if an accident occurs during resident transport without nursing staff present to assist. The non-compliance remained at the lowered scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for continued monitoring to ensure the policies and practices put in place were effective. This federal tag relates to Complaint IN00093639 and Complaint IN00094264. 3.1-37(a)			

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	155135	A. BUILDING 00 B. WING	07/29/2011

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F0323 SS=J	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to ensure 1 of 3 sampled residents reviewed for facility bus transfers was properly secured during the transfer resulting in the resident falling forward and laying face down for approximately 1 and 1/2 hours awaiting facility assistance. (Resident A) The Immediate Jeopardy began on 7/12/11 when Resident A was transported in the facility wheelchair van, without a	F0323	What corrective action was taken for those residents found to have been affected by the deficient practice? 1-The employee who drove the van with Resident A was suspended on 7/12/11 pending investigation. The investigation was completed on 7/13/11, and the bus driver involved in the incident was terminated. 2- A care plan was developed on 7/12/11 for Resident A addressing resident's refusal to wear seat belt. The approach was added that the facility would no longer transport resident due to her	07/30/2011

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	seat belt being in place. The driver of the van had to slam on his brakes when someone pulled in front of the van causing the resident to be propelled out of her wheelchair. The Resident lay on the van floor without medical assistance for approximately an hour and a half while the facility drove from Bedford to Indianapolis to assess her. The Administrator, RN Corporate Consultant and Director of Nursing were notified of the Immediate Jeopardy at 3:10 P.M. on 7/28/11. The immediate jeopardy was removed on 07/29/11 at 2:00 p.m., but noncompliance remained at the lowered scope and severity of isolated, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy. Findings Include: During interview of Resident A on 07/28/11 at 10:30 a.m., she indicated she had a "bad accident two weeks ago." Resident #A indicated she had gone out for a doctor's appointment in Indianapolis. Resident A indicated the driver had secured her wheel chair with straps, but she had refused to wear the seat belt due to she was too heavy and didn't like the way the seat belt "squeezed" her. Resident #A indicated upon arriving at		non-compliance. Alternative transportation will be arranged as needed. 3-A system is now in place for van transportation and for the timely and proper assessment when an incident occurs. How other Residents having the potential to be affected by the same deficient practice were identified? On 7/28/11, each interviewable Resident in the facility was questioned about seat belt compliance while riding in the facility van. All residents interviewed answered they would not try to remove the seat belt while riding in the van. As such, no other Residents were identified with the potential of being affected. What measures were put into place or what systemic changes were made to ensure that the deficient practice does not recur? 1-On 7/12/11, a plan was instituted to have the approved van drivers be instructed, before any other transports took place, on the proper use of the seat belts. Completed on 7/13/11, instruction was provided to those drivers including placing those drivers in wheelchairs and having each of those drivers seat belting each other in. They were also instructed on what to do when a resident refuses to use a seat belt as well as what action to take when a fall or accident occurs (to call 911) immediately, whether or not the Resident believes they were injured. Assessment of	

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	the hospital she was told the appointment had been canceled. Resident A indicated she left the hospital with the driver and continued to not wear her seat belt. Resident A indicated they were on the interstate and a car swerved in front of them and the driver had to slam on his brakes and she fell forward "almost to the front of the bus." Resident A indicated the driver pulled over to the side of the road and attempted to get her up off the floor but was unable to because she was too heavy. Resident A indicated she told the driver she was o.k. and the driver called the facility to report what had happened. Resident A indicated the bus driver told her that he was instructed by the facility to leave the resident on the floor until the facility arrived to help her. Resident A indicated it was very uncomfortable on the floor and she couldn't believe she had to lay on the floor until the facility arrived. The resident indicated she was on the floor 2 hours before the Administrator and LPN #1 arrived to assist her up. Resident A indicated the Administrator and the driver turned her over and sat her up and LPN #1 assessed her. Resident #A raised her shirt at this time and seven bright red ridges, approximately 4 centimeters in length and 0.5 centimeters in width were observed across the resident's abdomen. Resident A indicated the ridges were due to laying on		learning was return demonstration. The instruction that was provided to all current drivers will also be provided to any new drivers assigned the responsibility of transporting Residents. New driver instruction begins with a Job Specific Orientation which includes wheelchair and seatbelt safety, as well as calling 911 in case of an emergency, such as if a fall or incident occurs.How the corrective action will be monitored to ensure the deficient practice will not recur? 1-Return demonstration, which includes how to properly apply seat belts and calling 911 if an incident occurs, will be completed three times weekly on anyone who drives the bus for the next thirty days; weekly, for three months; and monthly for at least three months. 2-Results of these return demonstrations will be delivered to the Continuous Quality Improvement (CQI) Committee for ongoing Quality Assurance review and appropriate follow-up as needed. Date changes completed – 7/29/2011	

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	the bus floor. Resident A indicated she left the facility at 6:45 a.m. and arrived at the hospital in Indianapolis at about 8:45 a.m. Interview of LPN #1 on 07/28/11 at 11:15 a.m., indicated it took about 1 hour to get from the facility to Greenwood. LPN #1 indicated she was told by the driver and Resident #A that the wheelchair had been fastened in all 4 points, brakes were on, and tie down straps were on front and back, but the seat belt was not fastened. LPN #1 indicated the Administrator had called a sister facility near the area of the facility bus and were told that staff from the sister facility would leave immediately to assist the resident. LPN #1 indicated she called the driver and told him the sister facility was on their way. LPN #1 indicated the driver had given an incorrect location and the sister facility was on the west side and the facility bus was on the east side. LPN #1 indicated the driver had driven over to the east side with the resident on the floor of the bus. LPN #1 indicated the driver had followed Resident #A's instructions to get off of the interstate. LPN #1 indicated when she and the Administrator found out that the facility bus was at a different location they called the sister facility and instructed them not to come due to the Administrator and LPN#1 were on their way and were			

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	closer to the location of the bus than the sister facility. LPN #1 indicated she assessed the resident and she was moving all extremities. LPN #1 indicated Resident #A was face down on the mat when they arrived and was the exact same width as the aisle. LPN #1 indicated the resident denied any pain. LPN #1 indicated she and the Administrator slid a gait belt under the resident and after 3 attempts were able to move the resident to the back of the aisle where they could sit her up. LPN #1 indicated upon assessment of the resident, the resident was found to have red ridges across her abdomen, red blotches on her knees, and a bleeding elbow. LPN #1 indicated Resident A was able to tell her her name and where she lived and Resident A denied pain except a sore ankle. Interview of the Administrator on 07/28/11 at 11:40 a.m., indicated it didn't occur to him to call EMT's due to the resident saying she wasn't hurt. The Administrator indicated he had called the sister facility and they said they would go to assist the resident. The Administrator indicated he then called the van driver to confirm the location and the van driver told him he had moved the van and had driven about 8 miles farther. The Administrator indicated he then realized he was closer to the van than the sister			

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	facility so he called the sister facility and told them not to come. The Administrator indicated he wanted to make sure the resident was "seat belted in" when she returned to the facility so he made a special trip to insure the resident was properly secured during the transport back to the facility. The Administrator indicated he fastened the resident's seat belt, but did not realize that as soon as he turned his back she unfastened the seat belt and had it placed across her lap as if secured. The Administrator indicated the resident didn't request EMT's [Emergency Medical Technicians]. The Administrator indicated he was not aware the resident refused to wear seat belts. Interview of the DON on 07/28/11 at 2:15 p.m., indicated when the van driver called the facility to report what happened, her first thought was to call 911 due to EMT's would arrive sooner. The DON indicated the Administrator said he had talked to the resident and she was o.k. and a sister facility was going to the van location to help the resident. The DON indicated she was not aware the resident did not wear seat belts until the accident occurred, no one had reported this to her. Interview of the Nurse Practitioner on 07/28/11 at 2:30 p.m., indicated Resident A had requested an increase in her Xanax			

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	[anti-anxiety medication] on 07/14/11 due to the resident having trouble sleeping. The Nurse Practitioner indicated on 07/19/11, the resident complained of pain under her left breast. The Nurse Practitioner indicated the ridges on the resident's abdomen had opened and the dressing was sticking. The Nurse Practitioner indicated she palpated the resident's abdomen and the resident didn't complain of pain. Review of Resident A's clinical record on 07/28/11 at 12:55 p.m., indicated the following: Resident A had diagnoses which included, but were not limited to, CVA [stroke] and obesity. A quarterly MDS (Minimum Data Set) assessment, dated 07/01/11, indicated the resident was moderately cognitively impaired and was able to complete an interview for mental status, the resident required assistance of two staff for transfers and walking. A Resident Progress Note, dated 07/12/11 at 6:45 a.m., indicated, "Resident [A] LOA to Dr...[name of doctor] in Indy via facility provided transportation." A Resident Progress Note, dated 07/12/11			

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	at 11:00 a.m., indicated Resident A's vital signs were taken at that time and were as follows: Temperature - 97.3, heart rate - 80, respirations - 20, and blood pressure - 130/60. An X-ray, dated 07/12/11, indicated Resident A had "soft tissue swelling" of her right ankle. A Resident Progress Note, dated 07/12/11 at 1:00 p.m., indicated, "Arrived at van @ 11:00 a.m. resident lying face down in the floor/aisle of the van. Res [Resident A] denied any pain at this time. Res A&O [alert and oriented] to place, name, and staff present. Assessed face/neck, feet/ankles, and both arms for mobility. Denies any pain during the assessment. Gait belt was placed under the resident by ED [Executive Director] and LPN #1 & was hooked on her [Resident A] back side. ED lifted res slightly up while LPN #1 moved res towards the back of the bus from the aisle. 3 attempts and successful. ED, LPN # 1, and(driver of van) lifted res with gait belt and each leg to reposition res in a sitting position. Head to toe assessment done per this nurse. All vital signs WNL. Right elbow bleeding from a previous injury. Pressure applied. Bruising on both knees, sheering on her belly. Purpura [areas of discoloration] on left forearm. Small			

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abrasion on left elbow. Secured resident in wheelchair with should [shoulder] strap and lap belt and 4 point wheel belts. ED drove van and resident back to facility. This nurse notified DNS and DNS reported to [resident's physician], NP [Nurse Practitioner] at 12:30 p.m. regarding this incident."

A Resident Progress Note, dated 07/12/11 at 1:15 p.m., indicated, "Resident returned from MD [Medical Doctor] appointment...."

A Resident Progress Note, dated 07/13/11 at 1:46 p.m., indicated, "Resident up with assistance this shift. Resident received PRN [as needed] pain medication once this shift for general all over discomfort with effect. Resident was screen [screened] by therapy this shift and therapy is going to pick Resident up on caseload. Resident is propelling self in wheel chair to meals. Bruising continues to inferior left breast, purple in color. Slight discoloration also noted to left knee. Abrasions to abdomen have no signs or symptoms of infection. vital [sic] signs within normal limits, neuro checks WNL [within normal limits]. Call light in reach."

A Resident Progress Note, dated 07/13/11 at 3:30 p.m., indicated, "IDT

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	[Interdisciplinary Team] met to review residents fall on 7/12/2011 at 9:20 a.m. Resident fell out of chair while being transported to MD via facility van. Resident has several bruises and abrasions. Resident stated when the van stopped she fell out of her chair on to the van floor. When this nurse asked if she was belted in, resident stated, 'I wont [sic] wear a seat belt and if they put it on I [sic] just unhook it and hold it after they start to drive.' Neuro checks were started at the scene with nurse doing a head to toe assessment. MD/NP [Medical Doctor/Nurse Practitioner] and family notified. X ray to right foot and ankle done with no evidence of fracture. PT/OT to screen. Facility will no longer transport due to seat belt non compliance." A Resident Progress Note, dated 07/13/11 at 4:48 a.m., indicated, "Resident continues on F/U [follow-up] fall. Resident requested pain meds [medications] at 2:30 a.m. d/t [due to] hurting all over. Bruising noted to body in numerous places. Resing [Resting] quietly abed at this time." A Resident Progress Note, dated 07/13/11 at 10:14 p.m., indicated, "Resident cont [continues] on f/u [follow-up] for fall. Resident has had some complaint of pain this shift. Complaint of genral [sic] pain			

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	all over. Pain medication given. Resident stated it did help...." An X-ray, dated 07/20/11, indicated Resident A had no rib fractures. The Bus Driver Job Specific Orientation Program signed by the bus driver and dated 6/26/10, indicated "...Seatbelt (Required for all passengers/driver)..." An investigation form completed by the Director of Nursing, dated 7/12/11, indicated "...7/12/11 at 9:20 AM [sic] during morning meeting E.D. [Executive Director] received call from van driver (bus driver name). ED came to this nurse during meeting and told this nurse he and LPN (name) was going to assist van driver. ED stated van stopped and resident fell out of chair onto floor. After morning meeting at 10:10 AM [sic] this nurse called ED who was in route to van stating ambulance should be called in case of injury. ED had called sister facility in Indianapolis whom was close and DNS [Director of Nursing Services] with her staff was going to assess resident and assist if ambulance needed to be called. ED explained he had talked with van driver and resident whom stated she was fine. 7/12/2011 LPN (name) stated she did head to toe assessment and initiated neuro checks when she arrived at van location, on resident. ED drove van back to facility.			

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	7/13/2011 This nurse did head to toe assessment and measured each bruise and abrasion. This nurse asked resident how fall occurred. Resident stated (Bus driver name) stopped van and I fell in the floor. I asked if she hit her head and she stated no. No bruises or redness noted on resident's face. This nurse ask if resident was wearing seat belts and resident stated 'No I won't wear a seat belt and if they put it on me I just unhook it and hold it after they start to drive. I unhooked my seatbelt when (Administrator's name) was driving me back and he didn't even know it.' This nurse asked resident if she knew why the bus driver had driven while she was still in the floor. Resident stated "(bus driver name) kept saying get up (Resident A name) so I yelled at him to just drive and get me home." She also told this nurse she did not want (bus driver name) fired. This nurse explained to resident the possible injuries she could have had and the danger of driving without a seatbelt on. Resident stated 'I don't care I am not wearing a seatbelt.' Therapy to screen. Facility will not transport resident d/t [due to] non compliance with seat belt. Facility will arrange transport with (name) or (name) transit. 7/12/2011 xray of R [right] foot and ankle. No fracture or dislocation. 7/20/2011 Xray ribs no fracture, NP [nurse practitioner] saw and examined resident on 7/15/2011 and 7/19/2011."			

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On 7/28/11 at 2:50 P.M., in an interview with the Administrator, he indicated the facility would no longer transport Resident A because she refused to wear seat belt during transport. He further indicated he had spoken with the drivers and told them not to transport anyone who refused to wear a seatbelt, but he had not done an inservice.

On 7/28/11 at 3:15 P.M., in an interview with the Administrator he indicated there was no written statement taken from the bus driver concerning the incident with Resident A. He did indicate during an interview with the bus driver he had indicated Resident A had refused to wear her seat belt. The Administrator indicated the bus driver had been terminated because he violated facility policy because they are not to transport any resident without a seat belt.

Documentation titled "Activity Assistant/Bus Driver Job Specific Orientation Program" was provided by the Administrator on 07/28/11 at 11:00 a.m. The documentation was dated, 02/28/07. The documentation indicated, "...Transportation...Seatbelt (Required for all passengers/driver)...."

The facility van was observed on 07/28/11

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	at 4:30 p.m., to have narrow aisles which were approximately 20 inches wide. Two other resident charts were reviewed for transport of residents and indicated these residents did wear seat belts. Documentation titled "RE: Incident with Van Driver and Resident on 7/12/11" was provided by the Administrator on 07/29/11 at 1:30 p.m. The documentation was dated, 07/28/11. The documentation listed interventions the facility implemented to correct the immediate jeopardy. The facility immediately inserviced van drivers that any resident being transported were to be properly seat belted and drivers were instructed on what to do when a resident refused to wear a seat belt; Resident A was care planned addressing her refusal to wear a seat belt; the driver involved in the incident was terminated. In the event of a fall/accident while en route during a transport, and a resident is not accompanied by nurse to provide immediate assessment, 911 will be called for immediate assessment for the resident and the DON and Administrator will immediately be contacted. The immediate jeopardy that began on 07/12/11 was removed and the deficient practice corrected on 07/29/11 when the			

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	155135	A. BUILDING 00 B. WING	07/29/2011

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	facility provided information, dated 07/29/11 at 1:30 p.m., which indicated the driver of the bus had been immediately suspended and terminated after the investigation; all bus drivers were inserviced on not transporting residents unless they were properly seat belted; Resident A was care planned to no longer be transported by the facility due to her non-compliance with seat belts. Alternative transportation will be arranged as needed. The documentation indicated, "No resident will be transported without a seatbelt and/or wheelchair safety belt." The non-compliance remained at the lowered scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for continued monitoring to ensure the policies and practices put in place were followed and effective. This federal tag relates to Complaint IN00093639 and Complaint IN00094264. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0490 SS=J	A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review, observation, and interview, the facility failed to insure an effective system was in place to identify residents who refused to wear seat belts	F0490	What corrective action was taken for those residents found to have been affected by the deficient practice? 1-The employee who drove the van with Resident A was suspended on 7/12/11	07/30/2011

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	when transported in facility vehicles and failed to have an effective system in place to guide staff on procedures to follow when an incident occurred during van/bus transportation. This actually affected 1 of 3 residents reviewed for seat belt used during transportation. (Resident A) The Immediate Jeopardy began on 7/12/11 when Resident A was transported in the facility wheelchair van without a seat belt being in place. The driver of the van had to slam on his brakes when someone pulled in front of the van causing the resident to be propelled out of her wheelchair. The Resident lay on the van floor without medical assistance for approximately an hour and a half while the facility drove from Bedford to Indianapolis to assess her. The Administrator, RN Corporate Consultant and Director of Nursing were notified of the Immediate Jeopardy at 3:10 P.M. on 7/28/11. The immediate jeopardy was removed on 07/29/11 at 2:00 p.m., but noncompliance remained at a lowered scope and severity level of isolated, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy. Findings Include:		pending investigation. The investigation was completed on 7/13/11, and the bus driver involved in the incident was terminated. 2- A care plan was developed on 7/12/11 for Resident A addressing resident's refusal to wear seat belt. The approach was added that the facility would no longer transport resident due to her non-compliance. Alternative transportation will be arranged as needed. 3-A system is now in place for van transportation and for the timely and proper assessment when an incident occurs. How other Residents having the potential to be affected by the same deficient practice were identified? On 7/28/11, each interviewable Resident in the facility was questioned about seat belt compliance while riding in the facility van. All residents interviewed answered they would not try to remove the seat belt while riding in the van. As such, no other Residents were identified with the potential of being affected. What measures were put into place or what systemic changes were made to ensure that the deficient practice does not recur? 1-On 7/12/11, a plan was instituted to have the approved van drivers be instructed, before any other transports took place, on the proper use of the seat belts. Completed on 7/13/11, instruction was provided to those drivers	

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	During interview of Resident A on 07/28/11 at 10:30 a.m., she indicated two weeks ago she left the facility at 6:45 a.m., for a doctor's appointment at a hospital in Indianapolis. Resident A indicated she allowed the facility bus driver to secure her wheelchair with straps, but refused to be seat belted in her wheelchair. The Resident indicated upon arrival to the hospital at about 8:45 a.m., she was told her appointment had been canceled. Resident A indicated on the way home a car cut in front of the facility bus and the driver had to slam on his brakes, which caused the resident to be thrown to the front of the bus. The Resident indicated she was lying face down in the aisle of the bus and couldn't get up. The Resident indicated the bus driver immediately pulled over and attempted to get the resident up but was unable to. The bus driver called the facility and was instructed to leave the resident on the floor until help arrived. The Administrator had talked to the bus driver on the phone and was told by the driver that the resident was not hurt. The Administrator contacted a sister facility in Indianapolis and made arrangements for the sister facility to go to the location of the resident and provide assistance as needed. The Administrator left the facility at Bedford to go to the location of		including placing those drivers in wheelchairs and having each of those drivers seat belting each other in. They were also instructed on what to do when a resident refuses to use a seat belt as well as what action to take when a fall or accident occurs (to call 911) immediately, whether or not the Resident believes they were injured. Assessment of learning was return demonstration. The instruction that was provided to all current drivers will also be provided to any new drivers assigned the responsibility of transporting Residents. New driver instruction begins with a Job Specific Orientation which includes wheelchair and seatbelt safety, as well as calling 911 in case of an emergency, such as if a fall or incident occurs.How the corrective action will be monitored to ensure the deficient practice will not recur? 1-Return demonstration, which includes how to properly apply seat belts and calling 911 if an incident occurs, will be completed three times weekly on anyone who drives the bus for the next thirty days; weekly, for three months; and monthly for at least three months. 2-Results of these return demonstrations will be delivered to the Continuous Quality Improvement (CQI) Committee for ongoing Quality Assurance review and appropriate follow-up as needed. Date changes	

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	the bus at Indianapolis to drive the Resident back to the facility. Interview of the DON on 07/28/11 at 2:15 p.m., indicated when the van driver called the facility to report what happened, her first thought was to call 911 due to EMT's [Emergency Medical Technicians] would arrive sooner to help the resident. The DON indicated she suggested calling an ambulance in case the resident was hurt. The DON indicated she was told by the Administrator that he had talked to the resident and she was O.K. and the sister facility was on their way to provide assistance. During the trip to Indianapolis, the Administrator called the bus driver to confirm his location and found the bus driver had driven the bus farther and was no longer at the first location. The Administrator realized he was closer to the location than the sister facility so he phoned the sister facility and told them not to come. The Resident was assessed by LPN #1 upon arrival to the bus and was found to have right elbow bleeding from a previous injury, bruising on both knees, and sheering on her belly. Purpura [areas of discoloration] on left forearm and a small abrasion on left elbow.		completed – 7/29/2011	

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	Review of Resident A's clinical record on 07/28/11 12:55 p.m., indicated the following: Resident A had diagnoses which included, but were not limited to, CVA [stroke] and obesity. A quarterly MDS (Minimum Data Set) assessment, dated 07/01/11, indicated the resident was moderately cognitively impaired and was able to complete an interview for mental status, the resident required assistance of two staff for transfers and walking. A Resident Progress Note, dated 07/12/11 at 6:45 a.m., indicated, "Resident [A] LOA to Dr...[name of doctor] in Indy via facility provided transportation." Documentation titled "Activity Assistant/Bus Driver Job Specific Orientation Program" was provided by the Administrator on 07/28/11 at 11:00 a.m. The documentation was dated, 02/28/07. The documentation indicated, "...Transportation...Seatbelt (Required for all passengers/driver)...." The facility van was observed on 07/28/11 at 4:30 p.m., to have narrow aisles, which were approximately 20 inches wide.			

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Two other resident charts were reviewed for transport of residents and indicated these residents did wear seat belts.

Documentation titled "Timeline for [Resident A] incident was provided by the Administrator on 07/29/11 at 11:10 a.m. The documentation was dated July 12, 2011. The Documentation indicated the following:

"9:20 a.m. - Received call from bus driver that [name of resident] had fallen from her wheelchair and was on the floor of the van in indpls [Indianapolis]. Spoke with driver and [name of resident] on that call and determined that [name of resident] was not feeling any pain and in her words was alright. Told the driver that we would be coming to help and he told us their location.

9:30 a.m. - ED [Executive Director] and Nurse set out to help. ED needed to get to the site since it sounded like the driver had been careless allowing the resident to fall and thus, the driver should not drive the bus or the resident any further.

10:17 a.m. - The drive was going to be about an hour and a half, so in route , we contacted our ASC building [sister facility] just west of Indpls. I asked if

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	they could assist by going to the location of our bus, checking out the resident and waiting for us to arrive to the location. They said yes. 10:25 a.m. - Spoke with our bus driver and told him that we had called another center. The other center would be coming to his location to assist. Asked the driver to confirm his location. He informed us that he had driven to another location that 'has less traffic.' His new location was now closer to us and further from the [sister facility name] team that was in route to help. I told the driver to not drive any place and to stay at that location until our arrival. 10:30 a.m. - I called the [name of the sister facility] DNS [Director of Nursing Services] and told her that we were now closer than they were. They were in route to assist us. I thank [sic] them for their effort. 11:00 a.m. - We arrived at the location. Nurse performed initial assessment. We spoke with [name of resident] who said she was alright. We positioned [name of resident] better to get her into a sitting position. Nurse continued the assessment. We stood [name of resident] and placed her into her wheelchair. Nurse completed the assessment."			

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	On 7/28/11 at 3:15 P.M., in an interview with the Administrator, he indicated there was no written statement taken from the bus driver concerning the incident with Resident A. He did indicate during an interview with the bus driver he had indicated Resident A had refused to wear her seat belt. Interview of the Administrator on 07/28/11 at 1:30 p.m., indicated the Administrator was not aware of the facility having a policy regarding transport of residents. The immediate jeopardy that began on 07/12/11 was removed on 07/29/11 when the facility implemented the plan to immediately call 911 in the event of a resident who is not accompanied by a nurse has a fall/accident while en route during transport and inserviced all drivers as to what steps to take if a resident refuses to wear a seat belt. The non-compliance remained at a lowered scope and severity of isolated, no actual harm with potential for no more than minimal harm that is not immediate jeopardy because of the need to continue to monitor and ensure the policies and practices put in place were followed and were effective.			

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	Refer to F-309 related to the failure of the facility to ensure immediate assessment and care were provided to Resident A after the resident fell from her wheelchair on to the floor of the facility bus. Refer to F-323 regarding the failure of the facility to ensure Resident A was secured with a seat belt during transportation in facility vehicles, resulting in the resident falling from the wheelchair and being wedged in the aisle of the van. This federal tag relates to Complaint IN00093639 and Compliant IN00094264. 3.1-13(c) 3.1-13(q)			